LEARNING NEEDS SCREENING

CLIENT COPY

Highest grade completed *(K through 18)*.

Highest level of schooling, including certificated programs, training apprenticeships, etc.

High school diploma ☐ GED ☐ Technical/Vocational ☐
AA degree ☐ Other *(specify)* ☐

What kind of job would you like to get?

Have you worked in this field or a related field?

What makes it hard for you to get or keep this kind of job *(or any job)*?

What would help you find or keep a job?

We are going to ask you questions about your school experiences and your health. Your answers will help us figure out if anything is getting in your way with training and working. Your answers will also help you and your worker develop your Welfare-to-Work plan and decide what services you will need to be successfully employed. It is very important that you answer these questions so that you can be placed in the right kind of Welfare-to-Work activities and get the help and services you may need to succeed.

1. Have you had any problems learning in middle school or junior high?
2. Do you have difficulty working from a test booklet to an answer sheet?
3. Do you have difficulty or experience problems working with numbers in a column?
4. Do you have trouble judging distances?
5. Do any family members have learning problems?

6. Have you had any problems learning in elementary school?
7. Do you have difficulty or experience problems mixing mathematical signs (+/x)?
8. Do you have difficulty or experience problems filling out forms?
9. Did you experience difficulty memorizing numbers?
10. Do you have difficulty remembering how to spell simple words you know?

11. Do you have difficulty or experience problems taking notes?
12. Do you have trouble adding or subtracting small numbers in your head?
13. Were you ever in a special program or given extra help in school?
14. Were you ever in special education classes in school?
15. Have you ever been diagnosed or told you have Learning Disabilities?

    If YES, by whom? When?

16. Have you ever been diagnosed or told that you have Attention Deficit Disorder with or without hyperactivity?

    If YES, by whom? When?

17. Do you need or wear glasses?
18. Was your last vision test within the last two years?
19. Do you need or wear a hearing aid?
20. Have you had your hearing tested in the last 12 months?
21. Have you ever seen a speech or language therapist?

22. Have you ever had any of the following:

- ☐ a lot of ear infections
- ☐ a lot of sinus problems
- ☐ high fevers that lasted a long time
- ☐ diabetes (high blood sugar)
- ☐ severe allergies
- ☐ a lot of headaches or migraines
- ☐ a head injury
- ☐ convulsions or seizures
- ☐ serious health problems

23. Are you taking any medications that affect the way you think, act or feel?

    If YES, what are you taking?

    How often?

24. Do you need medical or follow-up services?